REPORT ON THE PROPOSED CONVERSION OF PREMERA

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- Washington State Hospital Association
- The Association of Washington Hospital Districts

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I. Executive Summary

There is a significant, demonstrable difference between the goals of a nonprofit health plan and a for- profit health plan. For-profit companies are operated with the ultimate goal of maximizing value for shareholders, and officers and directors of for-profit companies have an obligation to do this. As a public company. Premera will be subject to great scrutiny and pressure to ensure value is being maximized for investors. As a consequence, Premera will be forced to make decisions that benefit shareholders, but that are not necessarily in the best interests of the insurance buying public, policyholders, and providers. These decisions relate to the need to maximize returns and operating margins. Examples of techniques for doing this include raising rates for policyholders, cutting provider reimbursement, reducing benefits, and withdrawing from unprofitable lines of business.

Nonprofits are not "owned" in the same way public, for-profit companies are owned. The duties of officers and directors of a nonprofit are to the nonprofit mission. There are certainly similarities in the way for-profits and nonprofits are *operated.* Nonprofit health plans engage in some of the same techniques as for-profits to ensure the enterprise has sufficient revenue to continue the nonprofit mission. As a consequence, nonprofits may also withdraw from lines of business and raise rates. However, these actions are taken in the broader context and with the ultimate objective of serving the nonprofit mission, not maximizing value for outside investors or owners. The distinction in mission between for-profits and nonprofits provides nonprofits with greater flexibility to act in way that lessens or ameliorates impacts on stakeholders in the health care system, such as providers, policyholders, and the insurance buying public.

Because of certain characteristics of the insurance markets in Washington State, the proposed transaction has the significant potential to adversely affect providers, policyholders and the insurance buying public. Premera's dominance in the individual market in certain areas of the state gives the company market power over purchasers and providers in those areas. Because of the pressures of for-profit status discussed above, it is inevitable that Premera will be forced to exploit its market power to a greater extent than it may have in the past. This is likely to result in higher than otherwise expected rate increases, possible withdrawals from lines of unprofitable business, and restricted provider compensation. This is also the case in the small group market in certain areas. These actions are likely to increase the number of uninsureds in Washington. Studies show the uninsured have poorer health status compared to those who have insurance.

Part of the analysis of whether the transaction meets the statutory criteria must include determining whether the public will receive the fair value of the public assets of Premera. It is not clear that the IPO planned by Premera will result in the fair value of Premera being transferred to the state foundations. There are many unknowns and variables in this component of the transaction, including the current value of Premera. With the current record it is impossible to know whether the transaction is fair to the public. In addition, the deal as currently structured leaves Premera with excessive control over the distribution of transaction proceeds and stock.

Finally, although the transaction is likely to be hazardous to providers, policyholder and the insurance buying public, such negative impacts can be offset. However, as noted above, too many questions remain surrounding the foundation and its funding to allow for consideration of the foundation as an offsetting factor. Benefits to the public from Premera's access to capital should also be considered as a mitigating factor. However, the business case offered by Premera in support of the conversion is not compelling and has few specifics. As a consequence, there appears to be little to mitigate the negative consequences of the proposed transaction.

II. Introduction

This report was prepared for the Washington State Hospital Association and The Association of Washington Hospital Districts ("The Hospital Associations") in connection with the proposed conversion of the Premera Group ("Premera") from nonprofit to for-profit status in proceedings before the Washington Insurance Commissioner. Unless otherwise noted or referenced, this report is based on a review of the following material:

- Draft reports analyzing the transaction prepared for the Washington Office of the Insurance Commissioner (OIC) by retained experts and consultants, referred to as Reports 1-7.
- The Form A filing and accompanying information available on the website of the OIC.
- Relevant statutory provisions.
- Information relating to health insurance premiums and other consumer information available on the OIC website.
- A draft of the report "Premera Conversion Study; Review of the Literature and Experience of Other States" prepared by the Health Policy Analysis Program, School of Public Health and Community Medicine, University of Washington.
- A draft of the report "Premera Involvement in Washington and Alaska Health Insurance Markets" prepared by the Health Policy Analysis Program, School of Public Health and Community Medicine, University of Washington.
- Annual Statements for 2002 for Premera Blue Cross and LifeWise of Washington.
- "Premera Combined Financial Projections and Assumptions" (0016045-0016095).

This purpose of the report is to analyze the transaction as it impacts health care providers, policyholders, and the insurance buying public generally. This report examines actual and potential impacts on the availability and affordability of health care. The interests of hospitals are at risk as a result of the transaction in several ways. Potential consequences include restrictions in the provider networks and restrictions in provider reimbursement. These in turn can impact the availability of health care services to policyholders and the insurance buying public. In addition, increases in premiums, changes in benefits level and the discontinuance of lines of insurance also impact providers and the availability and affordability of insurance. Such restrictions on either

availability or affordability of health care can also increase the level of uncompensated care. Clearly, the interests of the stakeholders in the transaction, particularly providers and policyholders and the insurance buying public, are inextricably interwoven; however, they will be discussed separately as appropriate.

In many instances, this report relies on the factual descriptions of the transaction, the insurance markets in Washington, and rating information that are contained in the OIC draft expert reports, and except where noted, the accuracy of these description has not been verified. However, the conclusions contained herein are those of the author. Finally, a limited review of the final OIC Consultant Reports was made prior to completing this report, but time did not permit a complete review of the final reports. Therefore, this report may be amended or revised to accurately reflect the contents of the final OIC reports.

III. Relevant Statutory Provisions

The proposed transaction is governed by at least two provisions of Washington law, the Insurer Holding Company Act, and the Holding Company Act for Health Care Service Contractors and Health Maintenance Organizations, ("The Holding Company Acts"). The standards of review under each of these Acts is similar. The Insurer Holding Company Act provides in pertinent part:

> ***(4)(a) The commissioner shall approve a merger or other acquisition of control referred to in subsection (1) of this section unless, after a public hearing thereon, he or she finds that:***
>
> (i) After the change of control, the domestic insurer referred to in subsection (1) of this section would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which is presently licensed;
>
> (ii) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein. In applying the competitive standard in (a)(ii) of this subsection:
>
> (A) The information requirements of RCW 48.31B.020(3)(a) and the standards of RCW 48.31B.020(4)(b) apply:
>
> (B) The commissioner may not disapprove the merger or other acquisition if the commissioner finds that any of the situations meeting the criteria provided by RCW 48.31B.020(4)(c) exist; and
>
> (C) The commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

(iii) The financial condition of an acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(iv) The plans or proposals that the acquiring party has to liquidate the insurer, sell its assets, consolidate or merge it with any person, or to make other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(v) The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(vi) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

* * *

(Emphasis added)

R.C.W. 48.31B.015(4)(a)(i)-(iv)

The Holding Company Act for Health Care Service Contractors and Health Maintenance Organizations provides in pertinent part:

(5)(a) The commissioner shall approve an acquisition of control referred to in subsection (1) of this section unless, after a public hearing, he or she finds that:

(1) After the change of control, the domestic health carrier referred to in subsection (1) of this section would not be able to satisfy the requirements for registration as a health carrier;

(2) The antitrust section of the office of attorney general and any federal enforcement agency has chosen not to undertake a review of the proposed acquisition and the commissioner pursuant to his or her own review finds there is substantial evidence that the effect of the acquisition may be to substantially lessen competition or create a monopoly in the health coverage business.

If the antitrust section of the office of the attorney general does not undertake a review of the proposed acquisition and the review is being conducted by the commissioner, then the commissioner shall seek input from the attorney general throughout the review.

If the antitrust section of the office of the attorney general undertakes a review of the proposed transaction then the attorney general shall seek input from

the commissioner throughout the review. As to the commissioner, in making this determination:

(A) The informational requirements of RCW 48.31C.020(1)(a) apply;

(B) The commissioner may not disapprove the acquisition if the commissioner finds that:

(I) The acquisition will yield substantial economies of scale or economies in resource use that cannot be feasibly achieved in any other way, and the public benefits that would arise from the economies exceed the public benefits that would arise from more competition; or

(II) The acquisition will substantially increase or will prevent significant deterioration in the availability of health care coverage, and the public benefits of the increase exceed the public benefits that would arise from more competition;

(C) The commissioner may condition the approval of the acquisition on the removal of the basis of disapproval, as follows, within a specified period of time:

(I) The financial condition of an acquiring party is such as might jeopardize the financial stability of the health carrier, or prejudice the interest of its subscribers:

(II) The plans or proposals that the acquiring party has to liquidate the health carrier, sell its assets, consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to subscribers of the health carrier and not in the public interest;

(III) The competence, experience, and integrity of those persons who would control the operation of the health carrier are such that it would not be in the interest of subscribers of the health carrier and of the public to permit the merger or other acquisition of control; or

(IV) The acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

* * *

(Emphasis added)

R.C.W. 48.31C.030(5)(a)

This report will focus on the following factor, common to both statutes, although applied somewhat differently in each:

- Is the transaction likely to be hazardous or prejudicial to the insurance buying public?

IV. Analytical Framework: Is the Transaction Likely to be Hazardous or Prejudicial to the Insurance-Buying Public?

A. As a For-Profit Company, Premera Will be Pressured and Obligated to Maximize Value and Profitability for its Shareholders

The fundamental and material change to Premera as a result of the proposed transaction is the change from nonprofit to for-profit status. Even before undertaking the detailed "impact" analysis relating to market share, pricing, and provider reimbursement effects, it is critical that the broad and overarching significance of the change in corporate form be understood. To fully appreciate this change, is necessary to contrast the two forms of corporate ownership as well as the fiduciary duties to which the boards and management of the two entities are bound.

Non-profit entities have no "owners" in the traditional sense; rather there are "members" of the nonprofit. The absence of traditional ownership can create questions and confusion regarding the fiduciary duties of the board of a nonprofit and its management. One court summarized the duties of nonprofit officers and directors, as contrasted to those of for-profits, in the following way:

> "...[B]ecause the missions of the two types of corporations are different, the duty of loyalty is defined differently. The officers and directors of a for-profit corporation are to be guided by their duty to maximize long term profit for the benefit of the corporation and the shareholders. A nonprofit public benefit corporation's reason for existence, however, is not to generate a profit. Thus a director's duty of loyalty lies in pursing or ensuring the pursuit of the charitable purpose or public benefit which is the mission of the corporation."[1]

That there is a fundamental difference between the ultimate operational objectives of a nonprofit and for-profit has been fully recognized even by experts retained on behalf of Blues plans seeking to convert. Accenture Consulting, whose work has been relied on by Premera in the Form A before the Commissioner, made the following observation in the context of another proposed conversion, that of CareFirst, Inc., the combined Blue Cross/Blue Shield Plans of Maryland, Delaware and the District of Columbia:

> *"...Carefirst's first priority would be to earn a return for shareholders.* A change in corporate form would require CareFirst to introduce more stringent financial discipline in order to ensure more predictable, stable earnings in response to shareholder demands."[2] (Emphasis added)

This is not to say that there not operational similarities between nonprofits and for-profits. Clearly, nonprofit insurers must operate at sufficient margins, or earn a "profit" sufficient to process and pay claims with excess to fully fund reserves and surplus requirements of state regulators. But any operational similarities must be considered in the context of the distinctions in ultimate corporate purpose. As one commentator wrote:

> "In many respects, nonprofits and for-profits perform in ways that are indistinguishable from one another. However, this does not diminish the importance of the fundamental difference in their overall purposes. For-profits are legally and ethically responsible to their owners and/or stockholders, and are obligated to do well for the benefit of these owners; where markets function well, financial success will follow. Performance of for-profits can be measured most simply by profitability and return on equity for shareholders. Nonprofits, on the other hand, are directly responsible and accountable to the communities and populations they serve, and are legally and ethically bound to do "good" for the benefit of their communities. Therefore, nonprofits must measure their performance in terms of their quantifiable contributions to the public good of the communities they serve.
>
> Within the constraints of doing well enough financially to generate and access capital for current and future community needs, nonprofit health care organizations have been obligated to do as much as possible to meet society's needs for medical care and the improvement of health. Well-performing nonprofits do this by operating in ways that are measurable and consistent with the following set of values that support this special purpose and mission of improving health.[3]

The distinction in corporate purpose between nonprofit and for-profit gives rise to easily observed differences in corporate priorities as expressed by Blue Cross/Blue Shield executives. For example, in hearings before the Pennsylvania's Insurance Department on the issue of whether the state's Blue plans had accumulated excess surplus, the officers of the nonprofit plans highlighted their commitment to issuing affordable health care products, even if that meant cross-subsidizing the rates of some products with margins from others. According to the CFO of Highmark, Inc., a large nonprofit Blue plan:

> Currently, more than 63,000 people are enrolled in the Special Care Program statewide --- and thousands more have been in the program over the past 12 years. Blue Cross and Blue Shield programs such as Special Care are one of the reasons Pennsylvania historically has had one of the lowest rates of uninsured among the 50 states. In 2000, Pennsylvania's uninsured rate of 11 percent was the fourth lowest overall and the lowest among the populous states in the United States.

* * *

> *We strive to keep the cost of these special health insurance programs as affordable as possible, by charging less for the coverage than it costs us to provide.* For example, in the past five years, we have supported the Special Care program and the Children's Health Insurance Program by more than 55 million dollars.[4] (Emphasis added)
>
> * * *

The CFO of Independence Blue Cross (IBC), another Pennsylvania nonprofit Blues plan, testified about their commitment to mission and willingness to cross-subsidize products:

> In addition, since 1938, IBC has used surplus funds to reduce premiums for its non-group products. *For 2003, IBC and QCC will provide direct and indirect subsidies of over $18 million to those products.*[5] (Emphasis added)
>
> * * *

In sharp contrast to this view, Leonard Schaefer, CEO of Wellpoint Health Networks, Inc. ("Wellpoint"), a successful for-profit Blue Cross plan, testified that cross-subsidization is not an approach to pricing Wellpoint would tolerate:

> We try and make sure that every product we offer has value and every Product offers a return. So we would not want to sell products that have losses and we have an underwriting and pricing process to try and be very rigorous about that.[6]
>
> * * *
>
> *I don't think cross subsidies are ethical.* I don't think you overcharge a large group member so you can enroll a small group member. I think you find out what the real costs are and you build products that meet their needs.[7] (Emphasis added)

The use of cross-subsidization by nonprofits to keep health care affordable is an important consideration in the review of the proposed transaction. Courts have recognized and approved this practice as well. The Supreme Court of Kansas upheld the decision of the Kansas Insurance Commissioner to reject Anthem's proposed acquisition of the Blue Cross and Blue Shield of Kansas, Inc., expressly affirming the Commissioner's view that Anthem's projected profit margins would necessitate rate increases and an end to the cross-subsidization of the individual and small group markets.[8]

One recent study confirmed the value provided by nonprofits in the health care market. The study examined the differences in the community benefits provided by for-profit and nonprofit HMOs. According to the study:

"Nonprofit HMOs were significantly more likely to provide subsidies for medical services in the community and to support safety-net health care agencies, including support for community health centers and metal health centers. Nonprofit HMOs also were more likely to target their community benefit programs to low income neighborhoods in the communities that they serve.[9]

A clear illustration of the pressures that the management of publicly traded companies face to maintain earnings can be seen in the interactions between these companies and the Wall Street financial analysts who cover the companies. Company officers that participate in meetings or periodic conference calls with these analysts must explain and justify the financial performance of the company, provide earnings "guidance" for future performance and explain why earnings objectives provided in prior guidance were not met. The information provided form the basis for analysts reports, which in turn are distributed to investors. Clearly a company's failure to meet projections can have a negative impact on the analysts, and investors', appetite for the company's stock. The following except from one such call in 2002, involving Anthem provides some insight into the process, and the overriding emphasis on financial performance:

Anthem Trigon Earnings Review Conference Call – August 5, 2002

Tami Durte, Vice President Investor Relations, Anthem: Good morning and thank you for joining us. This is Tami Durte, Vice President Investor Relations.

* * *

Larry Glasscock, Chief Executive Officer, Anthem: Thank you, Tami and good morning to everyone.

* * *

I would like to highlight our second-quarter results. Anthem's second-quarter 2002 *earnings were $0.99 per diluted share an increase of 32% year-over-year* on a FAS 142 comparable basis. Excluding realized gains losses and the impact of our demutualization expenses in 2001. Our strong financial performance is the result of sustained disciplined growth strategy along with focusing on the needs of our customers . . . .

At the end of June, our enrollment reached 8.3 million members or an increase of 542,000 members from the same period last year. On the year-over-year basis membership is increased in all lines of business and is also grown in each of our states. *Most importantly, we're growing profitable enrollment.* Anthem's consolidated operating gain was $118.6 million a 62% increase over last year second-quarter results. Operating margin improved from 2.9% in the second quarter 2001 to 4.2% in the current

quarter. *The 4.2% operating margin reported this quarter represents the best in Anthem's history.*

* * *

Now, let me turn it over to Mike Smith our Chief Financial Officer who will discuss our second quarter 2002 financial results.

Michael Smith, Chief Financial Officer, Anthem: Thank you Larry and good morning.

For the second quarter 2002, net income was $106.2 million. Excluding the after tax impact of net realized investment gains, net income was $104.5 million or $0.99 per diluted share. *This performance was near the high end of our earnings guidance and resulted in a 32% year-over-year increase in earnings per share* on a FAS 142 comparable basis.

* * *

As Larry has mentioned, membership reached 8.3 million members at June 30, which represents a 7% growth rate compared to last year and a 5% increase in membership on a year-to-date basis. Our most recent enrollment guidance was increased from 4% to 5% and we have now already surpassed those expectations. This growth in enrollment along with premium yields of approximately 14% on fully insured group business drove operating revenues to $2.8 billion for the quarter. The revenue growth represents a 13% increase on a reported basis and a 19% increase on the same-store basis. We continue to build momentum in financial performance with $118.6 million in operating gain in the second-quarter. *This represents a $45 million increase or 62% growth over the comparable period last year.*

* * *

The improvement in Midwest financial results continues to benefit from disciplined pricing strategies and our enhanced ability to leverage the operating expense of our largest business segment. Midwest operating margin was 4.1% in the second quarter 2002. 70 basis points better than last year's comparable quarter.

Anthem East segment reported $52.9 million in operating gain in the quarter. *This resulted in a 5.3% operating margin and a 105% improvement in operating gain compared to the second-quarter of 2001. Like the Midwest segment, the East is pricing for profitable enrollment growth and enjoys god retention of membership while at the same time attracting new accounts. The East also benefited from improvement in its benefit expense ratio as medical cost trends came in lower-than-expected.*

* * *

Glassock: Thanks, Mike. Before I introduce Tom Snead to discuss Trigon's second-quarter results, I would like to take just a second to give you an update on the integration process. The Anthem Trigon definitive merger was announced on last quarter's conference call on April 29. Prior to the closing of the transaction which occurred on July 31, teams were put in place to focus on building strong relationships and lead a smooth transition. The transition teams are guided by the executive steering committee co-chaired by Tom Snead and Mike Smith. Over 200 people from Anthem and Trigon are involved in transition planning. Covering more than 16 different functional areas.

* * *

As a result of the work that has been done over the past 90 days, we remain highly confident in our projected pretax synergies of about $40 million dollars in 2003 and at least $75 million in annual pretax synergies by 2004.

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With that kind of background in place, I am pleased to introduce Anthem's President of our new Southeast Region Tom Snead.

Thomas Snead, President of New Southeast Region, Anthem: Thank you, Larry.

* * *

In all respects, the second-quarter was a continuation of our ongoing successes in the Virginia market represented by solid profitable and enrollment growth, disciplined pricing, effective cost management and a steady focus on providing high-level customer service.

Earnings per share excluding realized losses were $1.29 or about $0.10 above expectations. And 29% higher than the prior year second quarter. The higher-than-expected results came primarily from better-than-expected claims experience in categories of drug, outpatient and physician costs. With premium rate increases that were in the upper teens and sometimes higher, we continued to realize solid enrollment gains in both self-funded and fully insured business as well as very strong retention. Excluding Blue Card members total enrollment increased by 5.6% to nearly 2.2 million members, driven by about 4% growth in fully insured and about a 9% growth in our self-funded business. Excluding our Medicare supplement product growth was about 5% for the fully insured business.

Commercial premium revenues increased by about 15.9% to $612 million while fee income from our self-funded business increased by about 12.7% to $60 million. As we discussed in the past, *our long-term objective is to maintain our medical cost ratio in the 80% to 82% range* and for the quarter, our commercial medical cost ratio declined to 70.6% from 81.4% last year. This improvement was driven by the favorable claims experience which I previously mentioned. Days in claims was basically flat in the prior quarter at 65.1 days compared with 64.8 days in the first quarter of 2002.

* * *

Glassock: Thanks, Tom. Consistent with our past practice I just want to reemphasize that our guidance does not include the pending Blue Cross and Blue Shield of Kansas acquisition. However, I will provide guidance including obviously the acquisition of Trigon. With the Trigon merger being completed on July 31st of course only two months of results related to Trigon will be reported in the third quarter.

Excluding the impact of the Trigon merger, we now expect Anthem on a stand-alone basis to report earnings per share in the range of $3.90 to $4.00 for the full year 2002, excluding realized gains or losses. This is an increase from the $3.85 to $3.95 we previously expected. Including the impact of the Trigon transaction, 2002 earnings per share should be in the $3.85 to $3.95 range, with third quarter earnings per share in the $0.95 to $1.00 range. As we expected, this guidance represents about $0.05 of dilution in 2002 related to the Trigon acquisition. We continue to project a neutral impact to 2003 earnings per share and accretion thereafter.

For 2003, we expect earnings per share of $4.50 to $4.60 per share or at least a 15% growth as compared to Anthem's 2002 stand-alone guidance of $3.90 to $4.00 per share. We know that analyst estimates are currently around $4.56 per share; that falls comfortably within our current $4.50 to $4.60 expectation for 2003. The earnings fundamentals surrounding Trigon's business remained very strong and are essentially unchanged from the guidance provided last quarter.

* * *

Question: Since it seems that you have seen a deceleration of cost trends for both Trigon and Anthem, can you talk about whether you think your business mix or your contracting contributed partially to this, and your '03 pricing strategy now that you have seen the deceleration of costs, will this be built into your pricing for '03? Can you give us a general feel for enrollment trends? I know it's early but enrollment trends and pricing growth rates?

Smith: As we have done in the past, I am going to try my best. I've given you about a half a dozen reflection points on your question. First, it's too early for us to be giving guidance on premium increase for '03. *We will say as we said in the past that we are absolutely focused around pricing to cover trend and therefore as you observe, if trend subsides a bit that will be reflected in pricing.*

* * *

Question: If I'm hearing you correctly you are seeking decelerating cost trends so you are expecting to reflect that in your pricing for next year? Or are you waiting to see it trend out more before you assume that it's permanent and put it in the pricing?

Smith: We definitely want to see it trend out more and as you know, we are still very very early in any discussions for '03 medical cost trends. But we expect to continue to do as we have done to make sure that we price for gain and not for market share.

* * *

Question: Did you say that there was no change to Trigon guidance for earnings?

Smith: I will invite Tom Snead to join me as well. We have not changed Trigon's previously issued guidance from the first quarter. Tom Byrd has given you some indication around the strength of their operating gain and their sustained revenue growth but no material change in that guidance.

Question: The company beat the quarter by so much. Is that just conservatism or is there something that was one time and might reverse?

Byrd: As we talked about in the call, we had some unexpected claim experience for the quarter you will recall last year we communicated to you, that trends were increasing primarily driven by utilization and as time has come by, they last occurred to be better than we expected in earlier periods.

Question: So what you're saying is that much of the better-than-expected results in this quarter for Trigon were prior period positive developments?

Byrd: A portion if it was, Yes.[10]

This excerpt vividly illustrates how managers in public companies must focus like a laser beam on earnings, growing operating margins, and profitable growth. Notably absent from the discussion is the notion or any perceived obligation to provide affordable,

accessible health care. This is not to suggest any normative judgment about the for-profit model, or that such a focus on earnings is bad from a moral or policy perspective. It is simply a fact that must be recognized and understood as part of the review of the proposed transaction.

While the management of nonprofit Blues plans must understand, address, and manage to most, if not all, of the operational issues described in the excerpt above, including medical cost trends, product pricing, and enrollment growth, the public scrutiny of past performance coupled with the fiduciary obligations to shareholders creates a fundamentally different atmosphere in a for-profit. That atmosphere and obligation creates risk to policyholders and providers in a transaction such as that proposed by Premera. The issue is not whether Premera will be forced to undertake more aggressive efforts to improve profitability, but is only to what extent those efforts will be carried forward, and what is the likely impact.

B. Some Techniques that Health Insurers Use to Maximize Value Can Adversely Impact Providers, Policyholders, and the Insurance-Buying Public

1. The Techniques of Value Maximization

The overall profitability of a health plan is impacted by many factors, some within the control of the plan and others outside the control of the plan. Operating margins, taxes, and investment income all impact net income. Those factors most typically cited as impacting operating margins include premium levels, medical expenses, and administrative costs (often called "SG&A" or Selling, General and Administrative Expenses"). Medical expenses are in turn are determined by the rate or frequency of utilization of health care services by members, and the level of reimbursement by the plan to those who provide serves such as hospitals and doctors.

In some respects, utilization for services may be viewed as being outside the control of the plan. That is, plans can't control whether a member requires an emergency appendectomy, contracts viral meningitis, or breaks a leg skiing. However, through preventive wellness programs and medical management policies, plans do seek to control utilization. Wellness programs that focus on unhealthy behaviors such as smoking or overeating can reduce utilization by preventing or minimizing the onset of certain conditions. Medical management policies, particularly utilization review (UR) or utilization management (UM) can also serve to reduce utilization or ensure that the most appropriate and cost effective treatments are provided to a patient.

Other techniques can be employed to limit utilization, such as the exclusion of coverage for certain benefits. The reduction or limitation of a benefit will be governed by state law if the benefit is a mandated benefit, and by the market generally, if a benefit is not mandated but viewed as being important to perspective purchasers. However, while purchasers in the large group market may have purchasing or bargaining power to seek coverage of certain benefits in the contracts they negotiate, purchasers in the individual

market have no such power, and rely exclusively on whatever state or, in some cases, federal law, may require

Medical expenses can also be limited through the avoidance or management of certain risks through the underwriting or rating process. Through the application of underwriting standards, certain risks can either be avoided, or rated either to reflect the increased risk or at a level to discourage enrollment. The imposition of waiting periods, in which coverage for a pre-existing condition is limited, or the imposition of exclusionary riders, in which coverage is offered but treatment for a certain pre-existing medical condition is excluded, are other techniques for limited medical expenses. Studies have demonstrated that carriers in the individual market aggressively use this latter technique.[11] It is not clear to what extent Washington law permits such exclusionary riders.

The ultimate cost avoidance technique is the withdrawal of a particular product, or from a line of business. Such decisions involve a combination of financial and political considerations. They are financial for obvious reasons; either there is no basis to expect that losses in a line or product can be turned around, either because revenue (i.e. premiums) cannot keep pace with expenses, or the marginal gain from the product is not worth the capital investment to offer the product, and resources can be put to more profitable uses. They are usually also political because withdrawals from products or lines often leave large groups of individuals either without coverage, or with options that are more expensive than before, with more limited benefits, or both. As noted above, nonprofits have a demonstrated history in supporting unprofitable lines as part of their broader public mission.

The second major area of medical cost containment is provider reimbursement. Other than utilization levels, the rates paid to hospitals, physicians and other providers determine the level of medical expense for a given product. Health plans seek to walk a tightrope on the issue of compensation. To maintain adequate networks, sufficient reimbursement must be paid to ensure adequate participation. If too little is offered, there is a risk providers will not participate. Excessive compensation drives up medical expenses, which lowers operating margins, which can necessitate rate increases unless the plan decides to accept lower margins so as to not increase rates and risk the loss of enrollment.

The rates charged by a health plan impact the revenue side of the equation and also directly impact operating margins. Rate regulation varies from state to state, and the ability of state insurance regulators to enforce state law also varies. While rates typically must be neither excessive, inadequate nor unfairly discriminatory, as will be discussed below, in Washington the level of regulatory review is minimal for the individual and small group markets. While large groups have more leverage to negotiate over rates charged, purchasers in the individual market have no bargaining power and are therefore at particular risk for relatively larger rate increases. Health plans do not always seek to charge the "actuarially" justified rate, in some cases because it would force its members to seek coverage with competitors, and in some cases because of the potential public

outcry over the justified rate. In other cases, if a health plan has sufficient market power it can charge rates higher than are actuarially justified. It should be noted that the process of establishing rates involves a large number of assumptions about future trends involving claim rates, medical inflation, and utilization, and there is no single actuarially justified rate. Instead, typically a range of rates can be justified based on assumptions that are either more conservative or aggressive. Using aggressive assumptions will result in larger rate increases.

2. These Techniques Create Hazards for Providers, Policyholders, and the Insurance Buying Public

All of these techniques create hazards for the providers, policyholders, and the insurance buying public. Premium increases can lead to a decision to discontinue coverage for groups or individuals. Studies show that individuals without health insurance are less healthy than those with coverage.[12] The uninsured are less likely than the insured to have a regular source of care, are less likely to receive preventive care, and obviously are more likely to incur large medical bills if they do seek care.[13]

In addition, individuals without coverage often seek treatment in hospital emergency rooms, increasing the level of uncompensated care. One recent study examined the recent surge in hospital emergency room visits, noting an increase for the period 2000-2001 of 16% over the period 1996-1997.[14] While insured patients accounted for a larger percentage of the *increase* than did uninsured patients, overall the rate of visits to the ER by uninsured patients increased, causing the authors of the study to note:

> [T]he increase in visits by uninsured patients could have serious implications for crowding in public hospitals and other safety net institutions that treat a disproportionately high number of insured patients

Benefit reductions can also lead to untreated medical conditions for those conditions no longer covered, diminishing health status and possibly leading to uncompensated care. In the individual market, the reforms passed in 2000 mandated maternity coverage, ensuring coverage for this condition. However, other benefits were not mandated, and are not offered by Premera. For example, coverage for mental health services is not covered in all individual policies, including the catastrophic policy. Hospital emergency rooms are often the only source of treatment for individuals without insurance needing mental health services.

The use of exclusionary riders and waiting periods creates similar risks. Changes in utilization review standards implemented in order to reduce medical costs can also impact health and coverage status. Whether these are tempered depend not only on state law but on the ability and willingness to regulators to enforce the law.

Reduced provider compensation can reduce networks and impact the quality of care. In fact, this was an issue in the proposed conversion of CareFirst, Inc., where concerns were expressed over the aggressive negotiated techniques employed by the

potential acquirer, Wellpoint. In the Order and Report denying the proposed acquisition, reference was made to an instance where the D.C. Blue plan, GHMSI, had drastically reduced reimbursement to mental health providers, leading to an exodus from the network and, by GHMSI's own admission, compromising quality.[15]

Reduced provider compensation may have other impacts on the health care delivery system. One recent study examined the level of charity care provided by physicians and concluded that the level of such donated care was decreasing.[16] The authors opined that one cause of the drop was decreasing physician reimbursement:

> "A second factor that may be undermining the provision of charity care is the financial strain faced by many physician practices. Over the past decade, health plan and employer efforts to rein in health care costs resulted in lower payment rates to physicians and, for some, losses from managed care risk-sharing contracts. These conditions may have constrained practices' willingness to provide charity care."

Importantly and in conclusion, these techniques for cost management and revenue enhancement are not unique to for-profit plans. Most are practiced to varying degrees by all health plans, including non-profits. However, what is most important to recognize is that the pressure a publicly traded company faces to meet or exceed its projected earnings per share, to maintain its disciplined pricing ahead of medical inflation, to maintain or reduce its medical loss ration, to ensure products are not cross-subsidized and fully profitable, inevitably increases the pressure to utilize these techniques to a greater extent than do nonprofits generally. With this understanding, the following sections will examine in more detail the specifics Premera and the impacts of the Premera transaction.

V. Impact on the Individual Insurance Market

In reviewing whether the proposed transaction can be hazardous to the insurance buying public, it is most important to focus on those members of the public buying insurance in the individual market. These are the purchasers who have the least leverage with health plans, and who often have few options for coverage. One recent study found that between 1997 and 2001 premiums for individual converge increased nearly twice as fast as group premiums, about 14%/year compared to 7%/year for group coverage, and the number of people reporting coverage dropped by more than 1%, compared to .2% for group coverage.[17]

In short, individual purchasers are the most vulnerable population of buyers and therefore the most likely to suffer adverse consequences from a conversion.

A. Washington's Individual Insurance Market

Effective in 2000, the State of Washington made substantial modification to the laws governing the individual market after several health plans, including Premera, stopped writing new business in the market. These modifications include the following:

- Pre-existing condition waiting periods for new enrollees of up to nine months for conditions for which care was given, treatment sought, or for which prudent layperson would have sought treatment. The waiting period is triggered if treatment was sought or given within 6 months prior to the effective date of the policy.
- Credit toward to the waiting period for prior coverage under certain conditions.
- Establishment of a standard health questionnaire for the purpose of identifying the highest risk individuals who can obtain coverage through the Washington State Health Insurance Pool (WSHIP). Those who pass the medical screening shall be offered individual coverage.
- Individual policies are guaranteed renewable.
- Rates for the individual market are subject to a minimum medical loss ratio requirement of 72%, but otherwise are not subject to review by the OIC for reasonableness. Rates cannot be based on health status, although rating based on wellness factors is permitted.
- Rates for the high risk pool shall be no more than 150% of the standard average risk rate for indemnity plans, and 125% of the standard average risk rate for managed care plans.
- Individual polices shall contain benefits for maternity and prescription drugs, in addition to hospital, physician, laboratory and radiology.

In order to understand the impact of the transaction on the individual market, data regarding Premera's role in the market, and past, projected, and anticipated practices must be viewed in light of these and other statutory provisions.

B. Premera's Individual Business Market Share: Implications for the Proposed Transaction

As set forth in detail in OIC Expert Report 2, Premera's market share in the individual market for the state of Washington as of January 2002 is 47.90%. Premera has the largest market share in the individual market, and two other carriers along with Premera dominate the market with a combined market share of 93.72%. While the dominant player statewide, Premera is particularly dominant in Eastern Washington, where in 2001 Premera held 81.4% of the individual market. In some counties, it is the only issuer of individual products. Premera maintains individual business in both Premera Blue Cross and in the LifeWise of Washington subsidiary. According to the 2002 Annual Statements for the two companies, individual enrollment in Premera Blue Cross and LifeWise was 58,407 (compared to 70,877 in the prior year) , and 32,971 (compared to 11,953 for the prior year), respectively .

The lack of effective competition for business in the individual market for has several implications for the proposed transaction.

C. Impact on Rates

First, the absence of meaningful competition in the Eastern Washington market means that Premera has wide latitude in setting rates to maximize profits. According to Report 2, the Washington individual business has shown significant fluctuations in its operating margin since 1997, when it experienced large losses that presumably led to the decision to suspend writing new business. In 2002, on a statewide basis the business had a margin of (0.8%), excluding the largely profitable Medicare supplement business. Based on premium revenue of $157M, the line in 2002 appears to have generated a loss of $1.26 M. Individual business in Oregon and Alaska was profitable for the same year. Clearly, for all the reasons described in Section IV.A. above relating to the need for for-profits to maintain profitable lines of business, this line of business is especially susceptible to rate increases to ensure it operates at least at a profitable basis. (Report 2 does not break down the Washington operating results by Company (i.e. Premera vs. LifeWise of Washington) nor by region of the state (Eastern vs. Western)).

This qualitative view is confirmed by the data regarding both projected and target operating margins for individual business. According to Report 2, the projected margins for the Washington individual market (excluding Medicare supplement) is [ ] for the years 2005, 2006, 2007, respectively. As outlined in Section IV.B. above, these [ ] can be obtained either through rate increases, reductions in medical expenses, or significant improvements in the administrative expenses allocated to the individual line of business. While projections for targets for administrative expenses for individual lines of business have not been reviewed, the overall projected change in administrative expenses on a consolidated basis is [ ]. If this presents a guide for the planned reductions for the individual business expense ratio, then clearly to achieve the targeted operation margins for individual business Premera will be forced to make significant premium increase or take medical cost reduction measures, or both.

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In this regard, according to Report 2, the individual market would be under the greatest pressure for rate increase, and thousands of individuals in markets where Premera could exercise market power could experience increases of between 5% and 10%, depending on whether margin improvements were based solely on premium increases or in combination with limits on provider payments. OIC Report 1 indicates that rates are projected to increase 15.6% ahead of the rate of medical inflation.

While it is not clear exactly how many currently insured members would drop coverage due to these increases, or how many currently uninsured would continue to avoid entry into the market due to the expense of coverage, increasing rates generally depress the level of individuals with insurance. Studies consistently show that unaffordable cost is the number one reason people don't have private insurance.[18] For the reasons described above, this contributes to the level of uncompensated care and diminished health status for those individuals.

D. Impact on Providers

Premera's dominance in Eastern Washington creates substantial negotiating leverage with providers with whom Premera must contract to provide networks to Premera members. Although nationally some studies suggest that hospitals, for example, are in some cases responding to the superior bargaining position held by dominant health plans in contract negotiations, generally where a plan has such a dominant position hospitals and other providers must either eventually contract with the dominant plan or risk losing access to the plan's members.[19]

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Report 2 provides factual support for what one would expect to observe given Premera's market share in Eastern Washington. According to the report, the level of Premera's provider reimbursement in Western Washington is generally viewed to be[ ]In Eastern Washington, as one would expect given Premera's hugely dominant market share, Premera's level of reimbursement are reported by providers to be[ ] As also noted in the report, these differences in the reimbursement levels appear to be reflected in rate filings with the OIC. In these filings, area factors, which are permitted under the state's modified community rating law to capture differences in the cost of delivering care in different territories, show that the relative cost of care is less in Eastern Washington than in Western Washington.

Report 1 compared actual reimbursement rates to providers and in fact found that Premera is able to[ ] leading to the conclusion that Premera is clearly able to use its market power in negotiating with providers.

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Premera's dominance in the state, but particularly in Eastern Washington, creates significant risk to hospitals and other health care providers. With more than four times the market share of the rest of the market combined, Premera is in a position to force significant concessions from providers. While that activity appears to be occurring to some extent today, the pressures to maximize value and income for shareholders described above will provide a more immediate and real incentive for Premera to further leverage its market position. Further limiting reimbursement may be viewed as the "low hanging fruit" for a for-profit company. Squeezing ever smaller margins from hospitals and providers can impact their ability to operate effectively.

The modeling performed by Price WaterhouseCoopers relating to the projected rate increases described above illustrates the view that in those areas in which Premera has market power, margin improvements can be improved though limits on provider reimbursements.

While health plans argue that efforts to contain costs by limiting provider reimbursement inures to the benefits of its members, there is no guarantee that lower level of reimbursement will result in lower rates for policyholders. As discussed below,

improvements in the medical loss ratio driven by limits on reimbursement can be captured in the form of higher margins rather than lower rates.

One immediate example of the potential impact a conversion may have on providers is the new Dimensions insurance products. According to Report 2, Premera created a four-tiered network of providers based on the costs of the providers in the various networks. While there is substantial overlap in the networks, what is notable is that two of the three Dimensions networks, which are not HMO networks, have fewer hospitals than the HMO network of other Premera products. This is notable because normally HMO products are the most restricted of networks and have fewer providers than in nonmanaged care type networks.

The potential adverse impact on provider networks may be mitigated by network adequacy regulations. Washington has adequacy regulations, although they do not contain specific standards. See W.A.C. 284-43-200. Instead, these regulations permit carriers to establish network sufficiency with reference to "any reasonable criteria used by the carrier". Whether or not these regulations could serve to mitigate possible reductions in provider networks has not been determined.

E. Washington's Rating Laws May Not Limit Premera's Ability to Significantly Raise Rates

Washington State rating laws do not permit the OIC to review rates to determine if they are "reasonable" or "excessive." Instead, the OIC can review the rates simply to determine if the rates exceed the minimum loss ratio of 74% (less the applicable premium tax), but are expressly forbidden from impeding the implementation of new rates. The limited role that the cap plays in affecting rates can be seen in a simple example. If a carrier experienced an historical loss ratio of 80% and administrative expense ratio of 17% on its individual product, an operating margin of 3% is left as "profit". If provider reimbursement is cut, or premiums increased such that the loss ratio were lowered to 73% and the administrative expense remained constant at 17%, the company has increased its margin to 10%. By maintaining a loss ratio above the statutory minimum, the company is not subject to regulatory action. To the extent the margin improvements were derived from reducing provider reimbursement, these savings were not passed on in the form of lower rates. Instead, the margin improvement was captured by the company. To the extent the margin improvements were driven by rate increases, the rating law played no role in moderating the increase. Importantly, Report 1 finds that Premera continues to charge statewide rates for its individual products, notwithstanding differences it negotiated in provider costs, confirming that lower provider costs in that region are not necessarily passed on to consumers.

Another potential area of concern is the fact that in the individual market there is no cap or rate band between the highest and lowest variation from the community rate as there is in the small group market. This fact, coupled with the explicit ability to use age as a rating factor, means that through the use of age rating band carriers can aggressively price younger (i.e. healthier) individuals. Aggressive use of rating bands can be used as a

rough surrogate for health status since older individuals generally have higher medical costs than younger individuals. The aggressive use of age rating bands has a serious neagtive impact on the near elderly, those 55-65.

In short, Washington's rating law gives the carriers wide latitude to determine whether cost containment would inure to the benefit of customers or stock holders.

F. Other Observations

A number of other issues that relate to the impact the transaction may have on the insurance-buying public should be noted.

First, according to the OIC Expert Report 2, when Premera discontinued its participation in the individual market in the late 1990's, it continued to renew the block of existing individual business. When Premera re-entered the market, it wrote new business in LifeWise of Washington, a separately licensed, for-profit company. Although Premera also continues to offer Premera Blue Cross Individual products to new enrollees, new enrollees in Premera Blue Cross join the existing pool that includes older business acquired before the reforms and establishment of the standard health questionnaire. Thus, this pool has two strikes against it from an actuarial standpoint. First, it has individuals who were not "weeded out" by the health questionnaire. Second, its members are aging, which means their medical utilization is increasing. It is, therefore, no surprise that the rates for Premera individual products are almost twice those of LifeWise. This book has the characteristics of a closed block of business. Closed blocks of business are inevitably vulnerable to large rate increases if they are not permitted to operate at a loss. This is due to the fact that without younger, healthy new enrollees, the claims experience of the block deteriorates as members become older and sicker. With its comparatively high rates, Premera Blue Cross will not be able to attract younger, healthier enrollees and prices will spiral upwards unless subsidized. A for-profit Premera, with its emphasis on profitability, will experience great pressure to not subsidize the costs of this older, more expensive block of business.

The poor actuarial experience of this block will lead to not only large rate increases, possibly forcing people out of the market, but possibly a complete withdrawal from the line of business if it cannot be made profitable. Because Premera is a separately licensed carrier, it may do so without the obligation to move the book of business into the Life Wise products. In fact, Report 2 notes that Premera may phase out the individual business that was in place prior to the enactment of individual health care reforms. This was precisely the technique used by CareFirst, Inc. of Maryland. Because it had two affiliates operating in the same market, it was able to withdraw its individual HMO product, forcing the enrollees into the high-risk pool and not picking up those former members in the individual product offered by its affiliate. Such an action leaves those former insureds with the higher priced risk pool as the only converge option. Rates for coverage in the high risk pool may be up to 150% of the statewide coverage for underrated individual products.

Third, it is noteworthy that while Premera has set target margins of [ ] for the individual market, other products have noticeably lower targets. Given that on a relative basis the individual market generates the least amount of revenue of all the commercial, or governmental lines, it is not clear why it is targeted to require the highest profitability. According to Report 2, the margin on Washington state individual business, excluding Medicare supplement policies, was [ ] on [ ] in revenue, or a loss of [ ] in 2002. This may be contrasted with an identical margin loss of [ ] on the large group ASC business of [ ] The target margin for this line is [ ] The large group, risk market has premiums of [ ] in Washington in 2002, yet its target margin is only [ ] Given the large relative size of these markets, with their capacity to spread losses or expenses over a much larger population than does the individual market, it is not clear why a [ ] target for the individual market was selected.

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Fourth, there is no description in the reports regarding how these target margins were established, how they compare to other Blues Plans, and whether the assumptions underlying their development were reasonable. It has been noted in other transactions such as in North Carolina[20] and Maryland that plans undertook aggressive pricing and other revenue enhancing techniques in contemplation of the conversion. In North Carolina, Blue Cross Blue Shield of North Carolina set a profit target of 3% for the individual market from 1999-2001, but suddenly increased the target to 6% in 2002.

Fifth, there appears to be no analysis of the appropriateness of the administrative expenses associated with the individual lines of business. Administrative expenses are normally allocated to each line of business according to formulas and judgments made by management. Those expense allocations can significantly impact operating margins, because changes in the expense can translate dollar for dollar or percentage point by percentage point if medical costs are constant.

VI. Impact on the Washington Small Group Market

A. Washington State Small Group Market

The small group market in Washington is regulated similarly, but not identically, to the individual market. Like the individual market, rates must be made on an adjusted community rating basis. Geographic differentials are permitted based on the relative costs for the area, and without regard to specific health status of the group. Rates are permitted to vary by 375% of the community rate. Unlike in the individual market, Premera does incorporate geographic differences in its small group rates.

Premera has an overall market share in the small group market of 34.88% as of January 2002. However, as is the case in the individual market, Premera completely dominates the small group market in Eastern Washington, with 87.6% of the market. This dominance has resulted in the same conditions that characterize the individual market. According to OIC report 2, rate filings show that cost factors associated with Eastern Washington are below the state average, and factors for filing for Western Washington

are above the state average, suggesting the ability to negotiate lower provider rates in Eastern Washington.

Profitability for Premera in the small group market varies by region. In the East, small group business has experience negative margins since at least 1997. In 2002, data in Report 2 show a margin of [ ] on revenues of [ ] This loss [ ]on a larger book of business in the West. The operating margin in Western Washington has been [ ]since at least 1997, averaging above [ ].

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B. Impact on Rates and Provider Reimbursement in the Small Group Market

The impacts from the conversion on the small group market are similar to those likely to be experienced in the individual market due to the similarities in market share held by Premera in the to lines of business in the regions of the state. Certain conditions appear to make Eastern Washington especially vulnerable to the probability of rate increases. The overall small group business falls short of projected and target ratios due to the particularly poor performance of the Eastern Washington Business. If taken in isolation, the Western business has been exceeding the overall target margins. Clearly, for the entire line of business to meet projected and/or target margins, the rating structure and assumption for the Eastern business will have to be modified. Some combination of rate increases and cost containment would appear to be inevitable. Cost containment could include further reductions in provider reimbursements, or increases that do not keep pace with medical inflation. While OIC reports raise the possibility that certain expenses allocated to Eastern Washington business are excessive, this has not been verified. If expenses were reallocated within line of business such that the load for the small group business in Eastern Washington were reduced, then this would help to mitigate the need for large rate increases. However, like the proverbial balloon that expands on one side when squeezed on the other, if expenses are removed form the Eastern Washington business, it would need to be reallocated elsewhere, which would negatively impact the margin of that business.

VII. Fair Value Analysis

A. Does an IPO Provide Fair Value

Washington law provides that, in the event of dissolution of a not-for-profit corporation, the assets must be distributed in accordance with the applicable articles and by-laws or plan of distribution and that, in the case of a charitable corporation, the assets must be conveyed to one or more entities engaged in activities substantially similar to those of the dissolving corporation. Whether the conversion transaction proposed by Premera complies with those provisions is the subject of separate reviews by the courts and the Washington Attorney General. This report does not address those issues, and is confined to the questions presented to the Commissioner under the Holding Company Acts. In this regard, it is a fundamental premise of nonprofit conversions that the fair value of the converting nonprofit entity must be transferred to a succeeding nonprofit to

continue the nonprofit or public mission of the converting entity. The fair value of converting nonprofit must be preserved to carry out the nonprofit mission, rather than being obtained by the owners of the new for-profit entity. In the case of Blue Cross/Blue Shield conversions, this principle has been applied in a number of different ways. While typically private foundations have been established, such as in California with the conversion of Blue Cross of California, in other conversions proceeds have been directed to state medical schools (Wisconsin), the state general fund (Virginia), and more recently, to pay the salaries of health care workers in hospitals (New York). Maryland created a statutory foundation to receive conversions proceeds.

While the mechanism for preserving fair value to continue the public or nonprofit mission of the converting entity may differ from state to state, and arguments can be made regarding whether foundations are the best way to capture and direct conversion proceeds, one point is not in dispute: the full and fair value of the nonprofit must be preserved for the public. Failure to ensure that the value is transferred results in the unjust enrichment of the owners of the converted entity and the deprivation of the public's full entitlement to the benefits of the previous nonprofit's mission.

In the proposed transaction, there are critical flaws in the proposed transfer of value that are contrary to settled law and public policy. On the record developed to date, it does not appear possible to even determine if these flaws can be remedied.

First, there appears to be a threshold view that a properly conducted IPO guarantees that fair value will ultimately be received by the Washington Foundation. Under this view, fair value equates to fair market value under the assumption that a willing seller, Premera, and willing buyers, investors, meet in the market to determine Premera's market value. However, standard valuation techniques exist, as noted in the Blackstone report, than can be used to value a company, and which are used, among other things, to facilitate the issuance of fairness opinions. Even in the cases where initial appearances created the impression of a functioning marketplace, such valuations can serve as a check or validation to ensure fair value is being received.

In this case, the OIC consultant, the Blackstone Group, did not perform a formal valuation of the Premera in analyzing the proposed IPO and foundations using these techniques, although they did present a possible range of equity values of an IPO based on ranges of IPO discounts and various P/E multiples. According to Report 2, the "illustrative equity value" could range from $506M to $669M. Under this presentation, the value of the company could swing as much as 30%, depending on these two factors alone, the IPO discount and the trading level of the stock. Of critical importance is the fact that Blackstone reports that even this broad range may not reflect the value of the company:

> The value of the company at the time of the IPO *could be materially different* from the ranges presented due to, among other things, conditions in the equity capital markets, prospects for the company's performance,

state of the regulatory environment, and macroeconomic factors. (Emphasis added.)

Blackstone also expressly disavows that even the range of values noted above constitutes fair value, for it provided the following disclaimer:

> Implied equity value for the company [is] presented only for illustrative purposes and *is not any indication whatsoever* as to Blackstone's opinion as to the fair value of the company. (Emphasis added)

The only conclusion to be drawn is that there is massive uncertainty as to the actual value of the company and whether the public will receive fair value as a result of the conversion. The risk of this transaction to the public interest can be illustrated by contrasting the situation in another type of conversion, a sponsored conversion. These have occurred in numerous situations where a Blue Cross /Blue Shield plan is purchased by a consolidator such as Anthem, or Wellpoint. In these transactions, investment bankers separately value the entity being acquired to ensure that the value of the company that has been negotiated in the market is fair to the public. It has been the case that the initial price offered did not reflect the full and fair value. It is incumbent on the regulatory authority overseeing conversions to ensure that the actual full and fair value of the company be transferred. If that cannot be achieved, then the transactions should not be found to be in the public interest, and based on the record, there are no such assurances.

B. Specific Concerns with Premera's Proposal

Once the value of Premera is established through a formal valuation process, there are many difficult hurdles to overcome in determining whether the IPO could achieve that value for the Washington Foundation. These include the amount of shares initially offered, the amount and timing of secondary offerings, and the divesture requirements. In this regard the Blackstone Report notes what appear to be contradictory trend for consideration; the fact the BCBS IPOs in the past have demonstrated discounts of 28%-32% and at the same time out-perform the market post-IPO.

The OIC consultant reports also highlight numerous other deficiencies connected with the fair value requirement, largely relating to the governance of the Shareholder Foundation. To the extent the company, which has the ability to grant stock and options to management, is able to exercise control or influence in the affairs of the Shareholder Foundation, the structure for transferring value is flawed. The notion that the Foundation should indemnify Premera in the case on tax liabilities resulting from the change in corporate form is completely counter to the notion that the transaction would give the Washington Foundation fair value. Premera, not the public, should bear that risk.

VIII. Foundation Issues

There is another critical reason that the deal cannot be evaluated properly unless the fair value can be ascertained, and it relates back to the likely consequences of the transaction on the insurance buying public. As have the reports issued by OIC experts, this report has identified a number of actual or potential negative impacts resulting from the transaction, particularly as they relate to increases in rates, reductions in the availability of insurance, leading to individuals or groups declining to purchase coverage or being forced out of current coverage. To the extent such events occur, it would and should fall to the Washington Foundation to mitigate any negative consequences from the transaction. In other words, to fully measure the potential hazards to the insurance buying public, it is necessary not only to assess the hazards to the public, but also the potential scope of benefits that could result from the transaction largely through the Washington Foundation. At this juncture, it is impossible to know those benefits, in part because the value of Premera is not known, and in part because the allocation among jurisdictions of the fair value is not known. It is therefore impossible to calculate the capacity of Washington's health care system to ameliorate the negatives associated with the transaction.

It is also the case that the Washington Foundation may not be in the best position to maximize the benefits from the transactions. Studies have raised questions about the ability of private foundations to effect systemic change in the market to address state-wide health care needs[21]. This issue has not been reviewed and Premera has put forward no evidence on the issue. However, to fully comprehend not only the extent of any negatives but also potential positives, this issue should be examined.

IX. The Premera Business Case

Premera's filing with the OIC (Exhibit E-7) outlines the rationale for the proposed conversion. The reasons offered by Premera track those reasons offered in almost every nonprofit Blues conversion. According to the Exhibit E-7, Premera needs access to capital in order to invest in technology, develop new products, provide additional capital to support new growth, provide capital stability, fund implementation of state and federal law mandates, and provide flexibility for growth through acquisition.

Arguably, if it could be demonstrated that providing Premera the opportunity to access capital through a conversion would provide demonstrable benefits that might offset the negative consequences of the conversion, these potential benefits should be considered. However, there is little detail supplied to support the business case for conversion, and no clearly measurable demonstrable benefit that can't be achieved with the company in its current form.

Over the 5 year period 1998-2002, Premera Blue Cross has demonstrated significant revenue growth, from $1.3B in 1998 to $2.1B in 2002. Importantly, the net underwriting or operating gain for the company increased dramatically from ($13.9M) in 1998 to $24.3M in 2002. Net income dropped largely due to large drops in investment gains. However, the strong gain in underwriting margin is reflective of fundamentally sound operation. Apparently Premera believes this is the case as well. A review of the Premera annual report is an exceedingly upbeat and proud recitation of the company's financial strength. The report boasts of the following accomplishments:

- "Five year revenue growth : 74%"
- "Five year operating growth: $58 million"
- "Maintained medical expenses at 84-84% or premiums, reduced operating expense ratio, increased operating income"

The report is decidedly positive and reassuring, containing statements such as: "[T]he year capped a five-year effort to bolster operating performance and create a foundation for long-term stability following the operational turnaround in 1998 and 1999," and "[W]itch membership steady or rising, our brands expanding, the launch of Premera's new Dimensions suite of products and services, the company is strategically positioned to be the health plan of choice and standard of excellence in the markets we serve." While the Form A does not present a doomsday scenario for the company if the conversion is not permitted, the data and the company's own statements belie any sense of urgency to the proposal. While mention is made of the need to increase capital to support growth, no analysis is provide as to why, under applicable RBC formulas, premium revenue would not support that growth, and exactly how much capital would be need to support the growth projections in the business plan.

The record also shows that Premera has been able to pursue various strategic initiatives without access outside capital. The formations of the LifeWise of Washington plan and the roll out of the new line of Dimensions products and services illustrates this point. There has also been no demonstration of what technology initiatives have been deferred due to Premiere's nonprofit status, and no specifics on the new initiatives that would be funded. Nor has there been any indication as to what Premera's competitors are doing, and whether this has placed Premera at a competitive disadvantage.

In addition, as a general matter, the notion that nonprofit Blues plans are at an inherent disadvantage to those companies that have access to capital markets is not nearly as compelling as it was once thought to be. Recent reports largely take the view that nonprofits can survive and even prosper without access to outside capital. A recent report by Conning Research & Consulting, entitled "Blue Cross Blue Shield Plans; Roaring Back?" concluded that "[c]orporate structure of the individual BCBS organization is not a predictor of its financial performance."

Another study that reviewed the financial performance of for-profit and nonprofit Blue plans concluded that:

> Notwithstanding the advantages of scale and investor ownership, many of the most successful Blue plans in recent years have been nonprofits or mutual operating in just one state.[22]

X. Conclusions

As a for-profit company, the management of Premera will be obligated to maximize the value of the company for the benefit of outside investors. To meet this obligation, management will inevitably be forced to ensure that Premera's products are as profitable as the market and state law will permit. To do this, Premera will be forced to take actions to ensure profitability and higher operating margins, actions which may include rate increases, benefit or coverage restrictions, and limits in provider compensation. While some combination of these techniques may be employed by Premera now as a nonprofit, the pressures to increase earnings and profitability as a for-profit will inevitably lead to more frequent and aggressive cost savings and revenue generating measures. All of these actions negatively impact policyholders, providers and the insurance buying public.

There are no concrete or demonstrable benefits to policyholders, providers and the insurance buying public resulting from the infusion of capital into Premera resulting from the conversion that outweigh the negative impacts associated with the transaction. Furthermore, because of significant uncertainty over whether an IPO will in fact deliver the fair value of the company to a foundation, it is not clear or certain to what extent, if any, the foundation could offset the negative impact associated with the transaction.

[1] Summers v. Cherokee Children & Fam. Serv., Inc., 2002 WL 31126636 (Tenn. Ct. App.).

[2] Community Impact Analysis of the Proposed Conversion of CareFirst, Inc. To a For-Profit Business Entity and The Merger between CareFirst, Inc., and Wellpoint Health Networks Inc., January 2002.

[3] Metcalf, "Advancing the Role of Nonprofit Health Care," *Inquiry* (Summer 2002).

[4] Testimony of Robert Gray, CFO, Highmark, Inc., before the Pennsylvania Insurance Department, September 2002.

[5] Testimony of John Foos, CFO, Independence Blue Cross, before the Pennsylvania Insurance Department, September 4, 2002.

[6] Testimony of Leonard Schaefer, CEO, Wellpoint Health Networks, Inc., before the Maryland Insurance Administration, March 11, 2002 at 30-31.

[7] Testimony of Leonard Schaefer, CEO, Wellpoint Health Networks, Inc., before the Maryland Insurance Administration, January 31, 2003, p. 142.

[8] Blue Cross and Blue Shield of Kansas, Inc. v. Praeger, Kansas Supreme Court, 75 P.3d 226 (2003).

[9] Schlesinger, et al., "Measuring Community Benefits Provided by Nonprofit and For-profit HMOs," Inquiry 40: 114-132 (Summer 2003).

[10] "Sample of Available Public Information for Publicly Traded Managed Care Companies," prepared for the Maryland Insurance Administration in connection with the proposed conversion and acquisition of CareFirst, Inc. by Wellpoint Health Networks, Inc., dated November 15, 2002. On file with the Maryland Insurance Administration.

[11] Pollitz, et al., "Ensuring Health Security: Is The Individual Market Ready For Prime-Time," Health Affairs web exclusive, 23 October 2002.

[12] See e.g., Hadley, "Sicker and Poorer: The Consequences of Being Uninsured," Kaiser Commission on Medicaid and the Uninsured, May 2002; Schoen, "The Role of Insurance in Promoting Access to Health Care," the Commonwealth Fund, Briefing Note, January 2001; "The Costs and Consequences of Being Uninsured," Commonwealth Fund Publication #663 (July 2003); Weinick, Weigers and Cohen, "Children's Health Insurance, Access to Care and Health Status: New Findings," Health Affairs (March/April 1998).

[13] "The Costs and Consequences of Being Uninsured," supra.

[14] Cunningham & May, "Insured Americans Drive Surge in Emergency Room Visits," Issue Brief, Center for Studying Health Systems Change (October 2003).

[15] Report to the Maryland Insurance Administration regarding the Proposed Conversion of CareFirst, Inc., To a For-Profit Status and Acquisition By Wellpoint Health Networks, March 5, 2003, p. 201.

[16] Reed, et al., "Physicians Pulling Back From Charity Care," Issue Brief, Center for Studying Health System Change (August 2001).

[17] Chollett, Smieliauskas, and Konig, "Mapping State Health Insurance Markets, 2001: Structure and Change," Academy Health, State Coverage Initiative, September 2003.

[18] See e.g., "Income Adequacy and the Affordability of Health Insurance in Washington State," State Planning Grant Consultant Team, June 2002; Collins, et al., "On the Edge: Low Wage Workers and Their Health Insurance Coverage," Issue Brief, The Commonwealth Fund (April 2003); Gabel, et al., "Are Tax Credits Alone the Solution to Affordable Health Insurance?," The Commonwealth Fund, (May 2002); Results of the Small Employer Focus Group Project, Maryland Health Care Commission, May 2003.

[19] Devers, et al., "Hospital's Negotiating Leverage With Health Plans: How and Why Has it Changed?," Health Services Research 38:1, Part II (February 2003).

[20] Report of Ernst and Young to the North Carolina Department of Insurance With Respect to its Review of the Plan of Conversion As Submitted by Blue Cross and Blue Shield of North Carolina, April 14, 2003.

[21] Foundation Analysis Report to the Maryland Insurance Administration in Connection With the Proposed Conversion of CareFirst, Inc., February 11, 2003.

[22] Cunningham & Sherlock, "Bounceback: Blues Thrive or Markets Cool Toward HMOs," Health Affairs, January/February 2002, Vol. 21. No. 1.